Eastern Idaho Public Health (EIPH) COVID-19 Vaccine Administration Record (VAR)
Informed Consent for Vaccination – Time of Appointment: _____

First Name:	Last Name:	
Date of Birth:	Age:	Gender: Male Female
Social Security#:	Phone Number:	
Address:		
City:	State:	Zip:
Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other	**Ethnicity**: ☐Hispanic ☐Non-Hispanic	

Do you have health insurance? **If "NO" stop here. If "YES" please provide your insurance information.**

Insurance Company: _____ Group Number: _____

Policy/ID Number: _____ Policy Holder Name: _____Policy Holder DOB: _____

SECTION A

By signing, I/we consent to third party billing, if applicable and any balance left will be waived.

TREATMENT

Healthcare at EIPH may be provided by a certified nurse midwife, physician, physician assistant, nurse practitioner, licensed nurse, or other qualified professional. I/we also understand that I/we have the right to have my/our questions answered.

Immunizations

- I/we understand that immunizations are not mandatory and may be refused on religious or other grounds without reprisal. I/we understand information regarding vaccine(s) is available to me/us at EIPH. I/we understand the benefits and risks of vaccine(s) and ask that vaccine(s) be given to me or the person for whom I am authorized to make this request.
- I/we understand participation in and withdrawal from the immunization registry is voluntary. If you want to opt out or withdraw from Idaho's immunization registry (IRIS), call the Idaho Immunization Program at 208.334.5931.
- **I/we understand that it is recommended that I sit near the vaccination area for 15-30 minutes before exiting the building.**
- I/we authorize the release of my COVID-19 vaccine records to clinics, physician offices, employer, daycares and school. My authorization rights are available to me in EIPH's Notice of Privacy Practices.
- I/we understand that it is not possible to predict side effects or complications with receiving this vaccine.
- I/we have been offered a copy of the Emergency Use Authorization (EUA) form for the COVID-19 vaccine or have reviewed the EUA located at: https://www.cdc.gov/vaccines/covid-19/eua/index.html
- I/we have had a chance to ask questions and fully understand the benefits and risks the vaccine. If I/we have additional questions prior to vaccination, please call 208-533-3226.
- I/we consent to receive COVID-19 vaccine based on the Advisory Committee on Immunization Practices (ACIP) recommends at the present time.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)/PRIVACY PRACTICES

EIPH is required by law to maintain the privacy of your health information. Your information will be used for the purpose of treatment, payment, and EIPH business. You may request a copy of EIPH's privacy practices at any time. Individuals who pay in full and out of pocket for an item or service may request that their protected health information is not shared with their health insurance or health plan.
If you believe your privacy rights have been violated, you may file a written complaint to the Secretary of the Department of Health and Human Services or to: Privacy Officer: Eastern Idaho Public Health
1250 Hollipark Drive, Idaho Falls, ID 83401

By signing, I/we confirm that I/we have:

- Read and understand the above information;
- Been offered a copy of EIPH's HIPAA Privacy Practices;
- Been offered Emergency Use Authorization for the COVID 19 vaccine.

_____
Printed name of vaccine recipient/guardian

_____
Signature of client/parent/guardian Date

PLEASE FILL OUT THE BACK OF THIS FORM

SECTION B

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

7. Check all that apply to you:

☐ Am a male between ages 12 and 39 years old

☐ Have a history of myocarditis or pericarditis

☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

☐ Have a bleeding disorder

☐ Take a blood thinner

☐ Have a history of Guillain-Barré Syndrome (GBS)

Screening Reviewed and Education Provided by: _____Date: _____

EIPH Office: 1250 Hollipark Drive Idaho Falls, ID 83401 (208)533-3235		**Admin Codes:** Moderna 1st Dose 0011A 2nd Dose 0012A 3rd Dose 0013A Booster 0064A	**Admin Codes:** Pfizer 1st Dose 0051A 2nd Dose 0052A 3rd Dose 0053A Booster 0054A	**Admin Codes:** Pfizer 5-11 years 1st Dose 0071A 2nd Dose 0072A 3rd Dose 0073A	**Admin Codes:** Janssen 1st dose 0031A Booster 0034A	
Vaccine		**Lot Number**	**Provider Name and Title**	**Site**	**Route**	**Dose**
91301	**Moderna CVX 207**			Left or Right Deltoid	IM	0.5 ml
91306	**Moderna (BOOSTER) CVX 207**			Left or Right Deltoid	IM	0.25 ml
91305	**Pfizer CVX 217**			Left or Right Deltoid	IM	0.3 ml
91307	**5-11 Year old PFIZER CVX 218**			Left or Right Deltoid	IM	0.2 ml
91303	**Janssen (J&J) CVX 212**			Left or Right Deltoid	IM	0.5ml

Demographics	Super Billed	Checked Out / Insurance	Scanned